

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/15/2016	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00187603 completed on 12/1/15.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00189051 and Complaint IN00190136.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/20/2015. This visit included the PSR to the Investigation of Complaint IN00186499.</p> <p>Complaint IN00187603-Corrected.</p> <p>Survey dates: January 13, 14, and 15, 2016.</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Census bed type: SNF/NF: 98 Total: 98</p> <p>Census payor type: Medicare: 16 Medicaid: 58 Other: 24 Total: 98</p> <p>Kindred Transitional Care and Rehabilitation was found to be in compliance 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00187603.</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/15/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	Continued From page 1 Quality review completed by 26143, on January 21, 2016.	{F 000}			